BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **SHAKEEL A. KAHN, M.D.** Holder of License No. **37896** For the Practice of Allopathic Medicine In the State of Arizona.	**Case No. MD-15-0977A** **INTERIM FINDINGS OF FACT CONCLUSIONS OF LAW AND ORDER FOR SUMMARY SUSPENSION OF LICENSE**

The above-captioned matter came on for discussion before the Arizona Medical Board ("Board") at its emergency teleconference meeting scheduled for August 4, 2016. After reviewing relevant information and deliberating, the Board voted to consider proceedings for a summary action against Shakeel A. Kahn, M.D. ("Respondent"). Having considered the information in the matter and being fully advised, the Board enters the following Interim Findings of Fact, Conclusions of Law and Order for Summary Suspension of License, pending formal hearings or other Board action. A.R.S. § 32-1451(D).

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 37896 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-15-0977A after receiving two complaints regarding Respondent's opioid prescribing.

4. A Medical Consultant ("MC") review of four patient charts identified significant deviations from the standard of care relating to Respondent's prescribing of opioid medications.

5. Patient CD, a 29 year-old female, established care with Respondent on December 22, 2011 and she continued with Respondent through August 10, 2015. Respondent diagnosed CD with chronic low back and neck pain after a motor vehicle accident. The MC noted that CD would be considered a high-risk patient for opioid prescribing as she is young and enrolled in Medicare, actively using marijuana, alcohol and is a smoker. CD was also prescribed benzodiazepines. Respondent prescribed CD oxycodone 30 mg #360 for a 30 day supply. Over Respondent's course of treatment for CD, her opioid prescriptions were increased to: Methadone 120 mg/day, oxycodone 720 mg/day and hydromorphone 128 mg/day. The pain pattern for CD is usually not associated with severe pain.

6. Patient CEM, a 61 year-old male, established care with Respondent on December 19, 2012 with complaints of persistent back pain after back surgery. The patient had a history of facetogenic pain versus degenerative disk disease and not a candidate for re-operation. CEM's previous physician's last prescription for CEM was a two month supply of oxycodone 30 mg given in December, 2011. On CEM's first visit with Respondent, he prescribed #120 methadone 10 mg, and #300 oxycodone 30 for a 14 day supply. Respondent saw CEM every 15 days for the next three and a half years. Over the course of May-June of 2015, Respondent titrated the patient up to methadone 50 mg per day, oxycodone 720 mg/day and fentanyl patch 100 ug/hr. Respondent subsequently titrated CEM back down, and on the last visit reviewed, Respondent prescribed CEM #120 methadone 10 mg, fentanyl patch 50 ug/hr and #240 oxycodone 30 mg for a 15 day supply.

7. Patient CM, a 21 year-old male, established care with Respondent on March 13, 2012 with complaints of low back pain and migraine headaches. The MC commented that imaging studies conducted did not provide an explanation for the chronic pain.

Respondent prescribed CM #180 oxycodone 30mg, (180mg/day) and #120 Dilaudid 8mg, (32mg/day). CM's doses were adjusted on October 25, 2012 and Respondent prescribed CM oxycodone (210mg/day) and Dilaudid (24mg/day) in addition to soma 350mg t.i.d.. When CM reported overuse of his medications, Respondent increased CM's dose on February 14, 2013 to Oxycodone 270mg/day and Dilaudid 24mg/day. On the final visit in the record on August 10, 2015, Respondent prescribed CM oxycodone 660mg/day and discontinued CM's Dilaudid.

8. Patient AV, a 24 year-old male, established care with Respondent on April 3, 2012 with complaints of anxiety, obesity, low back pain and knee pain. Respondent prescribed AV oxycodone 150mg/day. AV had several early refills during his course of treatment with Respondent which were not accounted for with pill counts or changes in fill dates for the prescriptions. On the last visit of August 10, 2015, Respondent prescribed oxycodone 720mg/day along with Soma 350mg q.i.d. and Xanax 2 mg q.i.d.

9. The MC identified patients CD and CEM as high risk patients for opioid abuse or diversion and concluded that Respondent prescribed extraordinarily large doses of medication in all four patients. Respondent did not obtain records from prior treating providers for any of the patients reviewed. The MC noted that patient AV had been arrested and charged with selling his opioid medications.

10. The standard of care for prescribing opioids for a patient with chronic benign pain requires a physician to obtain records from prior physicians prior to establishing a diagnosis. Appropriate imaging to establish the diagnosis should be reviewed or ordered. A risk assessment should be performed to assure that the benefits of chronic opioid therapy outweigh the risk. Referrals for physical therapy, psychiatry, interventional pain and surgery should be considered. Dosages of medications should be individualized and adjusted to function rather than pain scores. The use of opioids should be closely

monitored with pill counts and making sure patients are not getting their prescriptions early. Additionally, benzodiazepines, alcohol, sedating muscle relaxants and marijuana in combination with opioids are relatively contraindicated. If the patient does not demonstrate an increase in function with increasing doses, the patient should be tapered to the lower dose and the lowest effective dose should be utilized. Urine drug screens with confirmatory testing should be utilized to measure compliance with the medical management and to detect the use of illicit substances.

11. With regard to patients CD, CM and AV, Respondent deviated from this standard of care by increasing the dosages of the patients' opioid medications without appropriate justification including a supporting diagnosis and by continuing to prescribe opioid medications without appropriate reassessment or monitoring for patient compliance.

12. With regard to patient CEM, Respondent deviated from this standard of care for a patient with an appropriate diagnosis to support the need for chronic opioid therapy by doubling CEM's opioid medications despite the patient's decline in function.

13. Respondent holds DEA prescribing authority numbers for both Arizona and Wyoming, where he also has an active medical license. Review of Respondent's Controlled Substance Prescription Monitoring Program ("CSPMP") profile, showed that Respondent wrote prescriptions for controlled substances including Oxycodone and Alprazolam for patient SP under both his Wyoming DEA number and his Arizona DEA number during the month of June, 2016.

14. The Board finds that the public health, safety and welfare imperatively requires emergency action.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

Based on the foregoing Interim Findings of Fact and Conclusions of Law, set forth above,

IT IS HEREBY ORDERED THAT:

1. Respondent's license to practice allopathic medicine in the State of Arizona, License No. 37896, is summarily suspended. Respondent is prohibited from practicing medicine in the State of Arizona and is prohibited from prescribing any form of treatment including prescription medications or injections of any kind until receiving permission from the Board to do so.

2. The Interim Findings of Fact and Conclusions of Law constitute written notice to Respondent of the charges of unprofessional conduct made by the Board against him. Respondent is entitled to a formal hearing to defend these charges as expeditiously as possible after the issuance of this Order.

3. The Board's Executive Director is instructed to refer this matter to the Office of Administrative Hearings for scheduling of an administrative hearing to be commenced as expeditiously as possible from the date of the issuance of this Order, unless stipulated and agreed otherwise by Respondent.

DATED this 5th day of August, 2016.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing e-mailed
this 5th day of August, 2016 to:

Shakeel A. Kahn, M.D.
Address of Record

ORIGINAL of the foregoing filed
this 5th day of August, 2016 with:

Arizona Medical Board
9545 E. Doubletree Ranch Road
Scottsdale, AZ 85258

Mary Bobey
Arizona Medical Board Staff